Paisley, 11th May 2018 11:00 – 3.30 pm

Precognition of

MARTIN GRAVES

My CV

I am asked about my CV. In terms of my experience as an expert witness, of the occasions (about 60) when I have given evidence in this capacity, on about 20 occasions this has involved restraint deaths where positional asphyxia and ABD (Acute Behavioural Disturbance) factors.

In relation to ABD, the police in the MET put in a lot of resources in 2009, after a death in custody in 2007. At that time I was training Manager at the Police College, Hendon in charge of Officer Safety Unit.

A National Committee was set up with direct responsibility in advising ACPO on Use of Force equipment. ACPOS (Scottish police) was represented on that committee and the information would have fed into the Scotttish police forces' training manuals. 90% of the content of Scottish training manual came from English manual.

I was instructed by PSD to look into this death. The MET put together a working party looking at how we dealt with mental health. This led to a report with recommendations. We then set up trials in Manchester, London, Liverpool with a training video about how safer restraint. Strathclyde police had a copy of that video. The trial was trying to prevent ABD deaths, with safer restraint, position of safety officer at front (head) and treating these cases as medical emergencies (calling an ambulance).

The Ambulance service in England have a cocktail of drugs that they hold on board for such cases – administer these drugs when subject has been restrained (like a tranquilliser).

I also mention in my CV that I continue to hold a current OST qualification. I am a regular tutor with college of policing and deliver training to police and others. For example I created and delivered an 8 week course in Sierre Leone. I am also

involved in delivering personal safety training to UK Border Force and to Immigration officers. I therefore continue to have a very active role. I have access to current manuals /training. I am the co-author of the training manual (Hendon College of Policing).

I am asked if all the appendices to my report that relate to the English (ACPO) training manual apply in Scotland. I would say that although the Scottish Force has its own Manual, the techniques are the same. They all go back to the same point of reference. (Comment that Scotland Police force just put a thistle on it.) For example you will see in the Scottish Manual, reference to the national Decision Making model (NDM). This has come from the ACPO Manual and it replaced the Conflict Resolution Model (CRM) which is now considered to be outdated.

Incident 3/5/15

The messages on airwaves were enough to highlight the high risk to the officers. There were two high grade calls. I would say that the second message 'upped the ante'. The officers start to think of officer safety, the 'what ifs', body armour etc.

PC Walker comments re thinking of hitting him with the police van. This is indicative of his mind-set before he arrived.

I am asked about the airwave messages about ARV/ dog van – what would they have brought to scene? I note in my report that the Sergeant requested both but it was some time before it was evident that these additional resources were not coming.

If a dog van had been available the dog would take the risk rather than the human. Dogs are trained to attack from a distance. The dog would be trained to bite the arm holding the knife. It's the same with Armed Response Vehicle. I would have thought that they would have Tasers, firearms and plastic bullets and shields on board.

I am asked if at that time there were signs for the police officers to recognise that Mr Bayoh may have been suffering from ABD. No, not enough at that point.

It could have been a domestic, road rage, or some other violent incident – not enough signs yet for ABD.

I am asked about the message heard on airwave on the Composite disc at 07:20:12 in which Inspector Steven Stewart advises attending sets that he is monitoring situation from an ARV perspective and informs sets that they require to make an initial assessment themselves on sighting the now deceased and feedback through channel. Inspector Stewart must have been the 'ARV bronze'. He was simply ticking a box on the despatch. It was a message from him to the Control room to let them know he was listening. He was not directing the initial officers to assess the situation (sit and wait). So, to be clear he was not directing PCs Paton and Walker told to hold off and assess first.

When Walker and Paton arrived they both adopted an assertive approach – what I would call a "hard stop." On page 26 of my report I say PC Paton could have used a more communicative style. The reason that I then go on to say that I do not think that this approach was the catalyst for Mr Bayoh's response was that the accounts given by the witnesses before this and the police about Mr Bayoh as looking 'crazy', makes me think he was already in a heightened state and standard communications would not have worked.

A 'softer' approach might have been a friendly, "how you doing". That was also a viable tactical option but it was clear to me from what they said about their discussion in the police van before they got there that they were going to 'jump him'. I would say that based on information they had, it was a reasonable option. In six out of seven calls about a person in possession of knife I would be very surprised if any officer would have tried anything different.

If an ARV had got there I would have expected a 'hard approach.' They would have jumped out with guns pointed – "get down on floor". That would have been reasonable approach had it been available.

Keeping a safe distance is very important. We talk in training about the 'TULER' drill. We say that a person with a knife out can cover 21 feet in distance in the time it takes an officer to draw a weapon.

I am asked about PC Walker's idea to drive the police van right up. I would not have done the same but Walker refers to using vehicle as cover. That's fair

enough. I think I would have kept a distance, stopped further up the road. One officer could have got out and asked to have a word. But there was nothing wrong with their choice of option. They made a decision to get in close and deal with him before he accessed the knife.

On page 26 of my report I say that the picture of Mr Bayoh suffering from some form of mental illness was becoming evident. Paton said he looked crazy. Mr Bayoh was obviously walking along, and there was no reaction to the Police vehicle. Were police thinking about knife or about ABD at this point? I would say that the knife was their focus. You can't be critical. They needed to confirm their safety and get the person under control and establish if he had a knife. From the point of view of an outsider he is not displaying signs of ABD.

I have no issue with the decision to spray CS and PAVA at Mr Bayoh. The use of these sprays allows officers can deal with the subject from a distance. I also have no issue if these first two police officers also got out of their vehicle holding a baton. They would be hedging their bets.

CS spray is better at incapacitating. PAVA has to go into the eyes of subject otherwise it does not work. I am not convinced that Mr Bayoh got a good dose of either spray. 8 – 10 feet is the maximum distance to reach the subject. The police officers say sprays hit him with no effect. My view is that they were too far away to have made an impact with sprays. However, if the sprays did make contact, his lack of response was another tick on list of signs for ABD.

There is no indication from their statements that PCs Paton and Walker considered ABD at that time. If sprayed back onto the officers they would suffer the effects: eyes would close, eyes watering, difficulty breathing, cough, wheezing. It's horrible; not nice stuff. How would police overcome those effects? Positive mindset – it was part of training when these sprays were first introduced.

CS is more likely to cross contaminate – that's why Paton was in a worse state. Walker had deployed PAVA and unless he got it in his eyes he would not have been affected same way.

I have no problem with the lack of a warning shout – he had been reported with a knife. Also, the police holding their sprays were clearly visible to Mr Bayoh.

Having been sprayed, PCs Walker and Paton were then 'out of it'.

PCs Tomlinson and Short arrived. No message had been passed by this time over airwaves – so no one else had update. Short and Tomlinson come to the scene with only the initial airwave messages to go on and so have less information than Walker and Paton now have. They have a clean slate. They think they are dealing with a male armed with a knife.

Tomlinson notes Walker holding his head. His perception based on what he sees (hands to face and jaunty walk) that his colleague had been slashed. Some evidence points to PC Tomlinson having a baton and spray out. I have no issue with that, given his perception.

I am asked to watch

Label 1 Composite disc containing the CCTV timeline.

I think the timing of the assault on PC Short would correspond with initial emergency button activation. (07:09:57) on CCTV. We then hear Paton saying "officer down….". That would allow time for "stamping" as described to take place. It's about 15 seconds until 07:10:12 when in camera view figure of Tomlinson delivering baton strikes to SB before he is brought down. This accords with statements I read.

Having read the statements my only issue was that I expected to see PC Short in the middle of road whereas it looks to me like the assault on her took place out of view, behind the smaller police van (vehicle 2 to the scene).

I am asked my opinion about PC Tomlinson delivering baton head strikes to Mr Bayoh. Such blows carry a risk of death or serious injury. The risk was high. PC Tomlinson's perception was that PC Walker had been slashed. Following that, PC Short has now been attacked and could be dead because of stomping (but that is a stretch). If it had been a firearms incident I would not have been surprised if Mr Bayoh had been shot. The police had a threat still in front of them. PC Tomlinson did not say in his statement if he realised that a head strike with baton could have been lethal. But he's not experienced, not long in service. We have found that was relevant to how people performed under pressure. There is

no substitute for experience (but also see note later re training gap re danger areas to strike).

Pc Tomlinson describe delivering two or three strikes to head and then two or three to the arms. Each strike has to be justified. I think he hit him once and didn't get a reaction so he has got locked into a cycle of hitting because nothing is happening (no response).

Is he justified in in using repeated blows? – Difficult – there has to be a time when you draw a line. Red mist situation? There has to be a time when you realise tactical option not working. 3 strikes and reconsider. I think it is difficult (to justify repeated strikes) but by changing target areas it shows that he is trying. He needs to try something else and that is when PC Walker comes in.

Walker too mentions thinking about using baton but saw it wasn't working and then changed his mind and took him down. There was a degree of 'lock-in' with Tomlinson's use of the baton but it was difficult for him to make a rational decision. He's expecting a reaction and when he doesn't get one he gets more stressed. His decision making rationale is reduced (see comments in my report, pages 29/30). It's up to him to justify it but it's understandable. He will attempt to rationalise it. My opinion is that he was locked in, evidenced by Walker's intervention. Walker realised the baton strikes were having no effect and took another option.

Walker takes over. I would do the same as Walker. I have no issue with a rugby tackle to ground. It can be the safer option.

I am asked if there were signs of ABD for PC Tomlinson to recognise. The level of risk was so high for the officers that it probably did not enter his mind at the time. I have included in my report some general comment about how stress affects officers involved in such incidents (pages 21/22 of my report) and these comments may be helpful in assessing PC Tomlinson's state of mind.

For PC Walker, there was another tick on the list of signs for ABD: Having not responded to CS and PAVA, Mr Bayoh had now been hit on head with a baton and had made no response.

I think if asked now if they thought about ABD they might say that they did, but their goal was to secure him. If ABD had been recognised they would have done nothing different, other than call an ambulance. (Although no opportunity to do so yet)

I am asked in this context about the comments by Prof Eddleston in para 22 of his report (Pro 884)

This was an armed man, in an open space, a danger to the public, a danger to others, a danger to himself. I did not think that the catalyst was the confrontational approach by police. He had been going down the middle of the road with a knife. Any suggestion that the reason he attacked police was because he was sprayed three times by them is a misnomer. He had been violent earlier on, had fought with his friend. All that information supports a hard approach by the police.

I am asked if police could have called for an ambulance before he was taken to ground (assuming ABD recognised). The issue is they did not have control yet. At some point they would still have to get control in order to get treatment if ambulance called. So there would still have to be a restraint. Police are not clinically trained – they are just trained to recognise the signs and know what to do.

I am asked if enough signs before restraint to recognise ABD and call ambulance. He would not have come quietly. The police would still have had to forcefully restrain him therefore no opportunity to call for an ambulance at that point.

Officers involved in restraint are not in a position to call an ambulance if actively involved in restraint. They did not have the chance or physical ability while restraining to stop and call. So even if they had begun to think of ABD they would have to wait until under he was under control.

I am asked to watch the CCTV of the restraint period including the snapchat 1.

Re PC Paton: he says that he reclaims his own baton and uses on bicep. That particular use of the baton is not in police training Manual. If you get it in the right position on a nerve cluster it will cause pain – in a rational person.

However I have no issue with use of baton in this way and indeed in England we use a similar technique using a baton on the legs to help restrain before leg - straps applied (shown in appendix D4 part 3, page 18)

PC Smith runs in and as he does so he provides the control room with the first update since officers have arrived on the scene. He was presuming too much when he passed the message that the male was under control. In fact the police were still fighting for control.

I am asked about what can be seen on Snapchat 1. This looks to me like a standard position of team restraint. The first two officers go for the arms. The next officer takes control of head or legs. Standard set up. It looks like one officer is lying across the legs. From reading the statements my impression was that this was PC Tomlinson lying across the legs of Mr Bayoh. (This position is shown in training manual – appendix D4 part 3 page 16). I would say that PC Tomlinson (I believe) is lying diagonally across the legs as shown in that picture.

It looks like a 'bog standard' restraint position on floor trying to get leg restraints on. In my view the Police officer lying diagonally across legs corresponds with Tomlinson. I don't see anyone lying across upper torso. I am sure PC Walker was at times lying over the torso of Mr Bayoh but that is not evident in that snapchat.

I am asked about asserting body weight as a method of restraint. It is impossible to control someone on the ground without using downward pressure. You need body weight. Even Paton using the baton was using his body weight. I have no issue with the restraint process.

I am asked if I have any issue with Walker using his body weight as described. As I said, from the accounts I read, there were times when PC Walker has been on top of Mr Bayoh, but then Bayoh bench presses.

Positional asphyxia is caused when you need more oxygen than you can get. Because of the position you are in there is a gap between what you require and what you have. (Cites example of man handcuffed to rear 10 mins in back of van – so not prone, but because handcuffed to rear, he was bent over and unable to breathe). There was a heightened requirement for oxygen because of activity earlier. Any restraint will reduce the subject's ability to exhale/inhale.

I am asked about whether PC Walker should now have recognised that Mr Bayoh was suffering from ABD. By now he has seen exceptional strength.

Walker had lot of ticks for ABD – should he have taken more care?

Yes ABD should be clicking in – especially for PCs Walker and Tomlinson who have the most information and had been there the longest. However I am still not too critical of them. The question to ask them is "did you consider?" They need to be asked the question. I assume they had not considered ABD but I would be very surprised if it was not in the back of their minds. Even so, I would question if they had the physical ability to do anything about it. They still did not have him under control. He is only under control when you know he is not going anywhere. They were not at that point yet.

Re CCTV snapchat 1 I am asked if I see a struggle. No, not really. But from the airwave message from Walker at 1min 14 secs – "handcuffed still struggling" I can hear heavy breathing and it sounds like a struggle was still going on at that point.

In the context of PC Walker stating that when he looked down after handcuffing achieved the leg straps already on, I am asked if it was usually the practice to apply handcuffs first. No, not necessarily; it would depend.

The entire period of four minutes for restraint is not excessive in any shape or form. It can take longer in a training environment if one of us trainers is being difficult.

On pages 33 and 34 of my report I say that PC Smith should have known and recognised the signs of ABD. I would have expected him to know the signs as an OST trainer. He has been told that CS Spray has not worked, there is a violent restraint going on, the male has already assaulted an officer and three of them are having difficulty in controlling him, he is displaying excessive strength and not complying with instructions. On Page 35 – para c. of my report – I say that the level of resistance was more than 'active resistance' and more like 'assaultive resistance'.

PC Smith states that he had no concerns when he first stood up after leg restraints had been applied. He considered but rules out excited delirium. In my

opinion he should have called an ambulance there and then. He does not do this until he goes down to check him. I'm critical of the delay between the point when he stood up, considered and rejected possible excited delirium to when he did call an ambulance when he found Mr Bayoh to be unresponsive. That is what could have been done differently. But, as I said in my report, that delay was a relatively short period of time.

I am asked about my comments under the heading of 'other witnesses' in my report. I have been asked about two eye witnesses whose evidence I have not referred to, namely Ashley Wyse and Christopher Fenton. I would class these two witnesses evidence as what we call "passing bus syndrome". Somebody has not seen what happened beforehand, the police are trying to do what they are trained to do, nobody was lying on top of him. I am asked what I made of her statement in particular about what she said about six police officers lying crossed over Mr Bayoh. I think it was a case of "passing bus". She has watched for about 10 seconds (the snapchat) and then gone for a cup of tea.

I am also asked what I made of the evidence of witness Fenton who mentioned the words 'scrummage'/ 'pile up'. I put him in the same category as Wyse. Eg a 15 second snapshot. He may have seen officers on top but reasonable officers on top of him. You can't restrain without police on top at some point. It is unlikely to have been constant. You can't restrain without using downward pressure. But bench-pressing means the person starts again when he gets a breath.

I am asked if there might be any reason for an officer to continue to lie on a person who has handcuff and leg restraints applied. Yes an officer could still lie on them to hold their legs down. I would expect officers to be around about. Somebody at the head, someone at the legs, for their own safety to stop them banging their head for example. The degree of restraint would be low.

I am asked about my comments at Point o. of my conclusions. I was involved in a restraint in custody leading to death. This occurred in . It brings me a heightened awareness of the importance of positional asphyxia. It also brings (maybe I should not say) an empathy for the officers involved in waiting for outcome. In the case I was involved with it went on for 2 years before the inquest and the internal investigation.

I am again asked about Prof Eddleston's view about the recognition of ABD and summoning an ambulance. Much of what he says relates to mental illness in a hospital environment. It is almost impossible to contain someone in an open area.

I would also say that once restraint starts, it is not an option to step back. You would always be asking "where's the knife?"

First Aid

I made some comment in my report about the difficulties in administering breaths during CPR.(pages 35 – 37) My main issue was about the kit used in the provision of first aid to Mr Bayoh. The face shields are absolutely rubbish. They disintegrate after about 30 seconds. HSE require First aid kits in vans. I would expect the first aid kit would contain a resuscitation kit – this usually has a face mask. The face shield they tried to use and discarded is not a face mask. I would have thought that at least one of the police vehicles there had a first aid kit with a face mask in it. I suspect that a first aid kit was available and nobody thought to go the van and get it.

RE Training

I made some comment in my report (pages 23 – 24) about the training materials with which I was provided.

It has been pointed out to me that I have referred to

Pro 547 Module 1 Officer Safety Theory

which was in fact a legacy Fife Constabulary training manual for Instructors of OST before 2013 (according to the statement of David Waterston). While I accept that these training materials may have been out of date and no longer in use at the time of May 2015, I would say that some of the officers (such as Pc Walker, Paton and Smith) would have been trained based on the principles contained in that manual, so it is of relevance.

I am asked today to look at

PRO 675 PSOS National Officer Safety Training Manual version 2.00

This had been provided to me. I am asked to make comment on the content of that training in that Manual so far as it relates to the issues raised by this case. I can confirm that the Scottish manual (PRO 675) does contain reference to the National Decision making (NDM) model, although it also contains reference to the older Conflict Resolution Model (CRM) which was phased out of OST manuals elsewhere in the UK as far back as 2004.

PRO 675 PSOS National Officer Safety Training Manual version 2.00

also contains the confrontational continuum (page 16), which again has been phased out now (in all parts of the UK) . In our review we found that while it was not wrong, officers were finding it too prescriptive. If an offender was described as showing resistance up to level 4 police officers were saying that they used force of level 4 or level 5. It was not wrong, but officers were perhaps being challenged about their use of force by reference to this table and it did not necessarily account of necessity and proportionality.

I am asked in particular if the information contained in

PRO 675 PSOS National Officer Safety Training Manual version 2.00

was sufficient for officers involved in this present incident in particular in relation to ABD (Excited delirium), Positional Asphyxia, and in relation to the use of batons.

In comparing the content of Pro 675 to the Appendices to my report (from the Current NPCC training manual) I would say that the NPCC training manual goes into more detail about the medical conditions of ABD and positional asphyxia. There was a seminar in 2016 or 2017 about ABD and Positional Asphyxia.

I am looking at Pro 675 PSOS National Officer Safety Training Manual version 2.00

and in particular, page 24 where it deals with Excited Delirium. When you compare that content with Appendix 3, of my reports, pages, 4, 5 and 6 – there is much more detail about ABD in the English manual. I am asked if the Scottish training manual had anything missing that might have been of help to the

officers involved in this case. I would say that absent is reference to unusual behaviour or bizarre behaviour. The causes are not as important as to how to recognise and deal with it. I would argue with the assertion in the training that cocaine was the most common drug causing it. I would say that the most common drug inducing ABD is MDMA. I would say that the content of the training was a bit outdated.

I am asked if the training that was in existence (PRO 675) was enough in providing the officers with the information to be able to identify the condition. It is difficult to make a judgement about the efficacy of the training without seeing how it was delivered. I would say that bizarre behaviour needs to be highlighted. The signs of ABD are more important to know than the causes. There is more information about how to deal with a person showing signs of ABD in the English training manual but the Scottish training manual does say to treat as a medical emergency and that's the most important bit.

I am asked about my comment in my report about the terminology being outdated. One example of this is the use of "excited delirium". We stopped using this term as medics told us that there was no such medical condition (although it is a term still being used in the US). We decided that ABD better described the condition as we are not really as interested in how it is caused. ABD covers it all. We changed the name because ABD is more medically relevant.

I noticed that the training manual (Pro 675) had nothing under the heading of 'Medical Implications' that might show or explain to officers what parts of the body might have a higher risk of injury. There is no mention under medical considerations of anything about the implications of baton strikes, punches or kicks. I looked for such guidance elsewhere in the manual and could find nothing.

In the past, we used to have charts in OST Manuals showing figures with red coloured zones showing danger areas for the genital area, head and spine. In England we moved away from this prescriptive diagram to something more general but highlighting the risks nonetheless. The reason for discontinuing the coloured chart was after one case in which an officer delivered a strike (punch) to the belly of a subject and he sustained a ruptured bowel, so what was considered a safer area to strike was not really so.

PRO 675 contains nothing to explain the dangers of striking someone on certain parts of body. If PC Tomlinson was asked if he had considered the danger of striking someone to the head with a baton we would not be able to point to something in Manual highlighting this warning.

PC Walker – I have no issue with him punching the deceased on face – natural reaction. "Older officer have older training in their heads."

RE the

PRO 859 PowerPoint presentation.

As spoken to by witness Agnew.

I note that he said it had not changed since he designed it in 2004 but the content re Positional Asphyxia and Excited Delirium seem on paper to mirror the content of PRO 675.

I see also from the Checklists (PROs 676, 677) they had to tick the checklist if they covered these topics (Positional Asphyxia and Excited Delirium) in refresher training.

However, when I looked at

PRO 678 SPELS manual

I noticed that the training about positional asphyxia did not mirror the training manual in place at the time (PRO 675) and that it contained misleading information about how positional asphyxia could be caused. It seemed to indicate that it could only be caused when a subject was prone (and I have earlier explained how this is not the case necessarily) and is only likely to occur with someone who is intoxicated, is obese or has a beer belly. This again is incorrect and there are other factors.

I am aware that in England in cases such as this where it is though that ABD might be a factor, it is a standard part of the PM to carry out a test for the chemical imbalance that indicates that the person was suffering from ABD. I believe that the test itself but it has to be carried out within 48 hours.

I made comment to Mr McLeod and Mrs Carnan in my telephone discussion with them after I received the materials and again today that it was a pity that the PIM process seemed not to have been followed in this case. I have carried out the role of PIM in my operational experience and while some officers do take the stance that they wish to say nothing, often getting a basic initial account from officers actually helps them at the end of the day as it helps the investigative process.

AM/FC